Committee:	**Healthier Communities and Older People Overview and Scrutiny Panel**
Date:	**12 February 2013**
Agenda item:	5
Wards:	All
Subject:	**Transition of Public Health to the London Borough of Merton**
Lead officer:	Dr Val Day, Interim Director of Public Health/ Simon Williams, Director, Community & Housing
Lead member:	Cllr Suzanne Evans
Contact officers:	Julia Groom, Joint Consultant in Public Health, Merton Anne Reeder, Public Health Transition Manager

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Recommendations:

That the Scrutiny Panel notes the progress of the Public Health Transition Plan for Merton and the transfer of Public Health responsibilities and functions to the London Borough of Merton.

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1. PURPOSE OF REPORT

The purpose of this report is to update the Scrutiny Panel on the progress made to transfer public health functions from the NHS to the Local Authority.

A report on the Public Health Transition will be going to Cabinet on 18th February 2013.

2. DETAILS

2.1 Local authority public health functions and responsibilities

2.1.1 The new public health responsibilities which come into place in April 2013 are intended to clearly demonstrate the leadership role for local authorities in:

- Tackling the causes of ill health, and reducing health inequalities
- Promoting and protecting health
- Promoting social justice and safer communities

The vision for local government leadership of public health is that health and wellbeing is integral to everything the Council does, and that health impact and maximising health benefit are systematically assessed during policy development. Specifically, local authority responsibilities for public health

leadership, commissioning and delivery will include mandatory functions and services, including:

- Production of the Joint Strategic Needs Assessment (JSNA), jointly with the Clinical Commissioning Group
- Leadership of the Health and Wellbeing Board and production of the Joint Health and Wellbeing Strategy
- Appointing a Director of Public Health to be responsible for its public health functions, including the planning and response to emergencies that involve a risk to public health
- The Director of Public Health must produce an annual report on the health of the people in the area of the local authority, which must be published
- Provision of public health advice to Merton Clinical Commissioning Group.
- Commissioning or providing certain mandatory services, including:
    - Appropriate access to sexual health services
    - Services to protect the health of the population
    - The National Child Measurement Programme
    - NHS Health Check assessment
- Commissioning a range of other public health and health improvement services, including Sexual Health, Substance Misuse, Child Health for 5-19 year olds, Smoking Cessation and Healthy Weight services.

2.1.2 The transfer of Public Health responsibilities is a significant opportunity for the Council to improve the health of residents and tackle health inequalities. The focus of recent activity has been on designing and establishing public health structures and ensuring robust systems are in place for the safe transfer of functions. However, it is important not to lose sight of the opportunities and potential for transformational change in delivery of public health outcomes. Developing a public health system where all partners are engaged, ensuring strong political and corporate leadership, embedding public health across all local authority functions and using the public health team to help local authorities to address all three domains of public health are essential.

2.1.3 Merton is well placed to meet its new public health responsibilities, building on a track record of addressing public health issues. The Merton Partnership has a long standing commitment to reducing health inequalities, as evidenced for example in its choice of stretch targets for the Local Area Agreement (LAA) Performance Grant. Its Healthier Communities Partnership was peer reviewed in 2007 and the Council was identified as providing effective leadership. Since that time partnerships have been maintained and developed, including the joint appointment of a Consultant in Public Health in 2009, the delivery of LAA targets to tackle health inequalities in 2010, and the development of the shadow Health and Wellbeing Board in 2011, which will become a statutory committee of the Council in April 2013.

2.1.4 Merton Council also has a track record of commissioning high quality public health services, including Substance Misuse services. The Council has worked in partnership with the PCT to help commission health improvement services, including Child Weight Management and targeted Sexual Health Services for young people. Most recently the Council has worked with the PCT to commission an integrated Health Improvement Service 'LiveWell', which from April 2013 will include Smoking Cessation services.

2.2 Appointing a Director of Public Health

2.2.1 A Director of Public Health (DPH) for Merton was appointed in December 2012 following an unsuccessful process in September. Induction and handover arrangements for the DPH are in place and a provisional start date is planned for 19th March.

2.3 Future Operating Model and Public Health Team Structure

2.3.1 Appointments from the Sutton and Merton Public Health team have been made to the Public Health Team for Merton. The core Team consists of DPH, 2 Consultants in Public Health, a Public Health Commissioning Manager, a Public Health Programme Manager, a Public Health Analyst and Business Administrator. Some vacancies still exist and recruitment to these posts is in progress. Members of the team who have been appointed have moved to the Civic Centre.

2.4 Future Public Health Commissioning Arrangements

2.4.1 Sexual Health services are currently commissioned across Sutton and Merton by two specialist Public Health commissioners. It has been agreed that the joint commissioning team should be retained and will be hosted by Merton, working across both councils. There will be an inter-authority agreement, which sets out time sharing arrangements based on each council's specific health needs.

2.4.2 The Smoking Cessation Service and the 'Live Well' service have been put out to tender as an integrated service and a new provider will be confirmed shortly.

2.4.3 The Sutton and Merton Community Services Block Contract with the Royal Marsden NHS Foundation Trust will transfer to five receiver organisations; Sutton and Merton CCGs, the London Boroughs of Sutton and of Merton and the NHS Commissioning Board. It has been agreed by the five organisations, that Merton CCG will be the lead commissioner, with legal agreements put in place between Merton CCG and the other four organisations.

2.4.4 Legal agreements will also be put in place for a lead borough to commission joint contracts between Sutton and Merton councils and in some cases, contracts which span South or South West London during 2013/14, while the contracts are reviewed.

2.5 Public Health Support to Merton Clinical Commissioning Group

2.5.1 The Health and Social Care Act 2012 mandates local authorities to ensure that NHS commissioners receive the public health advice they need. During 2012/13, this advice has been agreed and provided through a Memorandum of Understanding between Sutton and Merton PCT and Merton CCG. This is being reviewed during January 2013 and the findings will be used to inform the agreement between the London Borough of Merton and Merton CCG in 2013/14.

2.6 Finance

2.6.1 The Public Health Financial Allocations to local authorities for 2013/14 were delayed at the request of ministers in order to provide local government with definitive allocations for two years (2013/14 and 2014/15) in one announcement. The Public Health Grant was announced on January 10th 2013. The Grant for Merton is £8.985m for 2013/14 and £9.236m for 2014/15.

2.6.2 An initial analysis of the grant has been carried out and is attached as Appendix 1. Further detailed analysis and a comparison with the Public Health contracts and commitments is being undertaken and the results will be shared and discussed with the council's lead commissioning, financial and legal officers.

2.6.3 The Department of Health has allocated one off funding to local authorities to support the cost of transition. The methodology used to calculate the funds was based on PCT populations. This has disadvantaged both Sutton and Merton Councils and both Chief Executives have written to appeal the allocation. However, their appeal has been turned down.

2.7 Performance

2.7.1 Responsibility for the delivery of the majority of public health functions and the achievement of public health outcomes is being transferred to the local authorities. However, some functions are being transferred to other NHS organisations such as Public Health England (PHE) and the NHS Commissioning Board (NHS CB), for example, cancer screening and childhood immunisation services.

2.7.2 Local authorities, through their DPH "will have a duty to ensure plans are in place to protect their population including through screening and immunisation. DsPH will provide independent scrutiny and challenge of the plans of NHS CB, PHE and providers. PHE will support DsPH to hold the NHS CB to account through the provision of data and information on performance against standards.

2.7.3 Performance data for Sutton and Merton has previously been collected together and published as one set of information for Sutton and Merton PCT. Recently, some, but not all, services have been providing separate data for Merton.

2.7.4 The data tool for the Public Health Outcomes Framework was published in November 2012. This covers a period of 3 years and sets out the desired

outcomes for public health and how these will be measured. Some of the data is PCT level and therefore inaccurate at borough level. Although this has been taken up with the London Health Observatory who published the data, the historical legacy of published data that combines Merton with Sutton will continue. The Public Health Team will do more analysis on what this means for Merton Council in terms of being held to account against incorrect data. From April 2013 NHS provider organisations will meet the statutory requirement to collect data at individual borough and Clinical Commissioning group level. Non NHS providers who hold Public health contracts will also be required to provide borough level data.

2.7.5 The Public Health Team is currently working on a new performance report designed specifically for the London Borough of Merton.

2.8 Transfer Scheme and Order

2.8.1 The transfer scheme is the vehicle by which staff, contracts and other assets and liabilities will be safely transferred from the sending organisation (PCT) to the new commissioning organisations (including local authorities).

2.8.2 There are three separate Transfer Schemes: HR, Estates and Non-Estates. HR and some of the sections of the non-estates (including clinical and non clinical contracts, licences, IT and intellectual property) apply to local authorities. Public Health Transfer Schemes will be included as part of the total PCT Transfer Scheme for submission to the Department of Health. Unless the Transfer Schemes explicitly includes an asset or liability, it does not transfer but reverts back to the Secretary of State.

2.8.3 In advance of the actual transfer, there have been three 'uploads' of the data. Any further amendments to information contained within the transfer scheme will be through a formal change request process. The final upload will be returned to the PCT in March for final sign off by the Local Authority and PCT.

2.8.4 In Merton, Council and PCT officers have been working together to ensure safe transfer of functions, involving officers from Legal, Finance and Human Resources. This has included reviewing all the public health contracts that will transfer to the council, ensuring that funding is available in existing and estimated budgets to meet the contract costs, producing the staffing information required on the Transfer Order and confirming IT equipment and licences that are due to transfer.

2.29 The NHS London transition team has produced a slide pack setting out the process for contract transfer along with the key dates, owners and responsibilities (see Appendix 2) The aim is to make the process clear to people, including elected Members, who have not been involved in the detail so far.

3. ALTERNATIVE OPTIONS

3.1 Alternative options for the following have been considered by the Public Health Steering Group for Merton and the most appropriate option has been chosen to ensure continuity of services, financial viability and overall ability to deliver the public health functions:

- Structure for Merton Public Health Team
- Management of shared contracts
- Extensions of existing contracts

4. CONSULTATION UNDERTAKEN OR PROPOSED

4.1 Consultation on the proposed changes to the Sutton and Merton Public Health Team has been completed. Consultation of the transfer of staff to new provider organisations finishes in February 2013.

5. TIMETABLE

5.1 The Transition Plan is being delivered in line with national and locally agreed target dates. The Timeline for the Transfer Scheme is included in the Contract Transfer Scheme Briefing pack, in Appendix 2.

6. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1 The delay in announcing the Public Health Financial Allocations to local authorities for 2013/14 has had some practical implications for the processes of transition and transfer. The local authority has been waiting for the certainty of allocations as the basis for the final stages of planning, implementation and financial assurance.

6.2 Now that the Public Health Grant has been published, work is under way to analyse the grant and ensure that funding is allocated to cover all the public health commitments.

7. LEGAL AND STATUTORY IMPLICATIONS

7.1 The legal team are carrying out due diligence on all the contracts that will transfer to the Council. The Council's Scheme of Delegation has been amended to take account of the DPH's statutory responsibilities.

8. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1 The statutory duty on the Council for Public Health will include the reduction of health inequalities.

9. CRIME AND DISORDER IMPLICATIONS

None

10. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1 A risk assessment of the readiness and capacity of delivery of Public Health responsibilities by the Local Authority from April 13 has been carried out. Details are included in Appendix 3

11. APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

Appendix 1: Public Health Grant to Local Authorities – Merton
Appendix 2: Contract Transfer Scheme Briefing pack,
Appendix 3; Proposals for managing Public Health Risks following Transition to the London Borough of Merton

12. BACKGROUND PAPERS

None

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Appendix 1

Public Health Grants to Local Authorities

The Department of Health published the ring fenced grants for local authorities to spend on public health services for their local populations in 2013/14 and 2014/15 on 10 January 2013. As well as the allocations, details about the allocations formula, grant conditions and reporting arrangements were also published. Local authorities will, from April 2013, have a duty to take appropriate steps to improve the health of their population, and lead on reducing health inequalities.

The public health grant for Merton for £2013/14 is £8.985m and for £2014/15 is £9.236m.

Use of the grant

The public health grant is being provided to give local authorities the funding they need to discharge their public health responsibilities. They should be used to:

- Improve significantly the health and wellbeing of the local population
- Carry out health protection functions delegated from the Secretary of State
- Reduce health inequalities across the life course
- Ensure the provision of population healthcare advice

The grant is being made under Section 31 of the Local Government Act 2003 and there are conditions attached to its use, covering purpose and reporting. It is ring fenced for the purposes defined and the Chief Executive will have to confirm that the grant has been used for the required purpose. It may be used for both capital and revenue. It is expected that funds will be utilised in year but there is provision for any underspend to be carried forward as part of a public health reserve.

Mandated services are unchanged from the list originally published in December 2011. They are:

- Appropriate access to sexual health services
- Steps to be taken to protect the health of the population, including the duty to ensure plans are in place
- Ensuring NHS commissioners receive the public health advice they need
- The National Child Measurement Programme
- NHS Health Check assessment

How the public health grant has been calculated

The allocations are based on a starting position of historical NHS Primary Care Trust spend on defined public health services, uplifted for each of the two years by a percentage that takes account of distance from a target spend per head. The total national budget available is derived from PCT historical spend, uplifted for inflation and changes to the distribution of NHS resources as a consequence of the NHS reforms. The target is derived from a formula which has been recommended by the Advisory Committee on Resource Allocation (ACRA), based on detailed analysis of those factors which impact on a population's health needs and need for public health services.

The target spend per head of population is based on weighted population size which is the resident population adjusted for:

- Relative need – areas with higher need have higher shares, all else being equal
- Unavoidable geographical variation in the costs of providing services (the Market Forces Factor MFF) – higher cost areas have higher shares, all else being equal
- Age and gender – some public health functions are clearly directed at certain age and gender groups
- For drug services previously funded through the Pooled Treatment Budget, resident populations for 2013/14 are retrospectively adjusted for outcomes

The weighted populations are converted into a target proportion of the total national budget available and converted into monetary allocations. Where there is a difference between current spend and target allocation, Pace of Change policy determines the final allocations. The policy applied means that an uplift on the 2013/14 starting position of between 2.8% and 10% has been applied, depending on distance from target.

ACRA recommendations and their impact on Merton

ACRA's recommendations include a number of factors which generally favour those populations in poor health and with the greatest need. It follows, therefore, that they impact negatively on the application of the formula in Merton.

- Standardised Mortality Ratio (SMR)[1] for those aged under 75 years, applied at MSOA[2] level to take account of inequality within local authorities as well as between local authorities:

[1] SMR is a measure of how few or many deaths there are in a local area compared with the national average, having adjusted for the differences between the age profile of the area compared with the national average. A higher SMR<75 represents a higher relative number of deaths. The age of 75 is commonly used as a measure of premature morality

MSOAs are split into ten groups based on their SMR<75 and each of the groups is assigned a weight from one to five. Those MSOAs with the highest SMR<75 have a weight per head that is five times higher than those MSOAs with the lowest values, reflecting that public health needs and costs increase with higher SMR<75.

There are 25 MSOAs in Merton, spread across groups 1- 6. Eighteen of the 25 MSOAs are in group 4 or below, which are weighted below 2, and the average weighting for Merton is 1.52. The SMR<75 at MSOA level varies from 57.6 to 122.8, where 100 is the SMR for England. This reduces the 2013 population estimate of 210,344 to a weighted population of 149,050.

- Market Forces Factor (MFF):

  The MFF Index accounts for variations in unavoidable geographic costs of providing public healthcare services between local authorities. It is applied to the weighted population so that local authorities in higher cost areas receive additional funding to ensure that they can afford the same level of services relative to need as those in other areas.

  The MFF for Merton is 1.11. Effectively this means that 11% is added to the SMR<75 weighted population to give a weighted population size of 165,936.

- Mandatory and non-mandatory age-gender adjustments:

  Age-gender adjustments have been applied to recognise the cost of those services with the highest proportion of public health spend which are also directed at specific age-gender groups to weight for relative needs between different age-gender groups.

  There are six public health services for which age-gender adjustments are calculated:

    - Nutrition, obesity and physical activity
    - Alcohol misuse
    - Tobacco misuse
    - Sexual health
    - Children's services age 5-19
    - Drug misuse

[2] MSOAs are populations of about 7000 defined by the Office for National Statistics which are widely used for statistical analysis to make comparisons between small geographical areas

Weighting is calculated for each of these areas separately and then applied to the relevant weighted population. For Merton the weightings are: 1.04 mandated services, 0.99 non-mandated services, 1.20 drug misuse, 1.06 alcohol misuse.

- Pace of change:

  The final allocation is determined by Pace of Change policy, which sets the differential growth in allocations which local authorities receive. The starting position is taken from 2010/11 baseline spending estimates as published in February 2012, adjusted for PCT updates and uplifted to 2012/13 values.

  For Merton, the target allocation is set at £8.531m which is £42 per head. The actual allocation is 5.3% above target. The 2013/14 increase is 2.8%, which is the minimum increase and reflects that the opening baseline is 2.5% above target.

Reconciliation of the public health grant to previous estimates

Our working basis for planning public health services for 2013/14 has been the baseline spending estimates published in February 2012, uplifted to predicted 2013/14 values. These estimates were based on actual spend for 2010/11 by NHS Sutton and Merton.

The working estimate for Merton for 2013/14 was £7.618m. This is the baseline spending estimate for 2010/11 uplifted to 2012/13 of £7.469m as published, uplifted by 2% to allow for 2013/14 inflation. During 2012 detailed work was undertaken to identify where the 2010/11 estimates fell short of actual spend, which was submitted to the Department of Health in August. The detail now published shows that the baseline was increased by £1.110m to reflect PCT adjustments. It is important to recognise that this increase reflects real costs of services such as estates and corporate overheads that were not originally identified, together with service costs not included in the original return. In addition small adjustments have been made by DH for the Drug Interventions Programme (£105,000) and surveillance and control of infectious diseases (£56,000). Urgent work is underway to firm up the contract values for 2013/14 which will be financed from the public health grant.

Dr Valerie Day
Director of Public Health (Interim)
15 January 2013

Contract Transfer Scheme briefing pack

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Background / Context

The core principles that underpin the contract transition process can be found within the PDF document

Transfer-Document ation-Guidance

The key principles are summarised below :

- Appropriate arrangements to be in place between PCT and Local authorities / CCG / NHSCB / PHE commissioners to ensure continuity of clinical care for patients and service users during the transition

Guidance: Commissioning fact sheet for clinical commissioning groups
http://www.commissioningboard.nhs.uk/files/2012/07/fs-ccg-respon.pdf

Guidance : Public Health in Local Government Commissioning responsibilities
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131901.pdf

- Consistent and objective approach
- Openness and transparency
- The responsibility of the PCT as current contracting authority is to prepare their contracts for the smooth transfer to the future contracting authority on 1 April 2013
- Full engagement by the future contracting authorities during the 2013/14 contracting round is essential to ensure the smooth transfer of contracting arrangements

Stages of contract transition

Stage 1 – Stocktake
PCTs submitted information on all of their primary care, specialised and 'other' (including LES) contracts to Department of Health (DH) in March 2012. The data were wider ranging than just Public Health contracts but provided details on value of contracts, length of contracts, total contracts to be transferred and number of contracts that would need to be re-commissioned.

Timeframe:
It is envisaged that LAs and PH teams should have completed the stocktake exercise for all Public Health contracts by the end of July 2012

Stage 2 – Stabilisation
This phase sought to reconcile any discrepancies, plug any gaps and plan for transfer of contracts. Insofar as it was possible, LAs and PH teams started to map out which contracts were transferring to which receiving organisations, including other local and regional bodies (e.g. CCGs, NHSCB, PHE). Uncertainty regarding these new regional/national organisations meant that this stage took longer to progress than anticipated as it was dependent on clarity and conclusiveness of information being given by the new organisations.

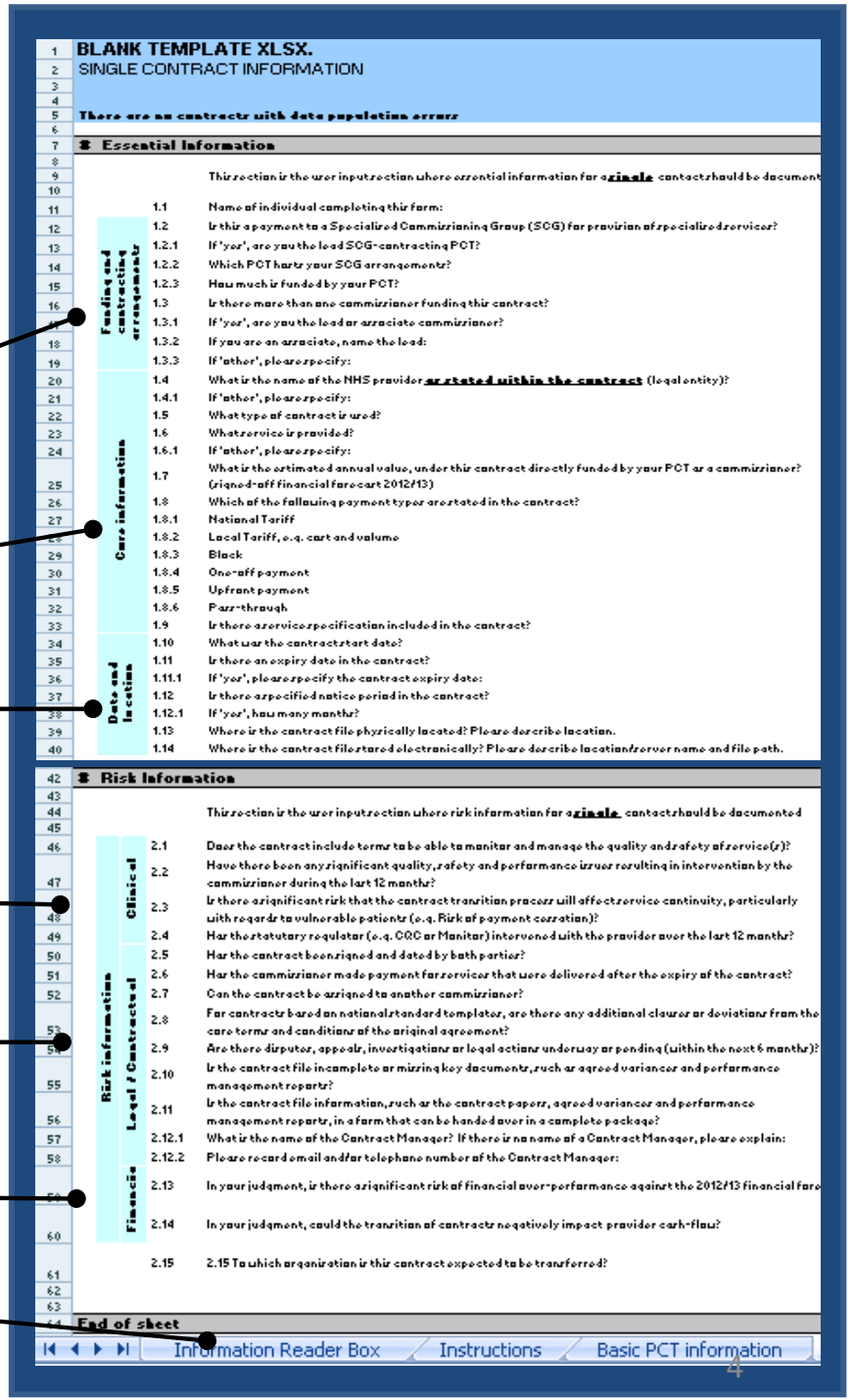
Timeframe:
It was proposed that LAs with their PH colleagues work towards a deadline of end of September 2012 for completing this stage.

Stage 3 – Shift
All transfers (of staff, property and contracts) to their receiving organisations will only take place formally on 31/3/2013. These will be the Transfer Schemes. The period from October 2012 onwards should be used to finalise all the details of all the contracts for inclusion in the schemes, based on all the work undertaken in the stocktake and stabilisation phases.

Timeframe:
The transfer of contracts will officially take place on 31 March 2012. However, a number of draft uploads of the transfer scheme will be carried out in advance on the 15 November 2012, 13 December 2012 and 17 January 2013.

Stage 1 - Stocktake

A data capture tool was developed by the Department of Health to ensure that all the contract details were recorded. This template required 146 questions to be populated to ensure that every aspect of the contract was captured. This included provider details, financial information, performance information, supporting documentation, contract start and end dates to name a few.
A summary table shows an example of some of the questions requested in the detailed spread sheet.



Funding and contracting arrangements

Core information

Date and location

Risk information - Clinical

Risk information - Legal / Contractual

Risk information - Financial

14 further data tabs that hold the detailed breakdown of each type of contract

Guidance : Transition Controls Data Capture Tool
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131712.pdf

Stage 2 – Stabilisation – due diligence process

As part of the stabilisation phase a due diligence process was undertaken to capture how boroughs were progressing. A series of questions were asked on how many contracts were being novated, re-tendered and terminated; whether block contracts were planned to be disaggregated in advance of April 2013; whether any information was still outstanding; what the key perceived risks were to the workstream; and their degree of confidence in delivering the workstream.

The boroughs used this opportunity to identify some key risks; these have been summarised below and suggested mitigating actions:

Risks	Mitigating actions
Shortfall in financial allocations therefore reduced service levels	Where possible develop contingency plans using set criteria to prioritise contracts that must be delivered as part of the mandatory functions and other local, political priorities.
Disaggregating block contracts within given timeframe	Where information and resources are available commence disaggregation, however If you **do not** have the capacity or all the relevant information, it is still advisable to start now to achieve disaggregation in 2013/14. You may consider alternative contracting mechanisms until disaggregation is achieved e.g. S75/ S76 agreements with CCG
Lack of paperwork for some contracts	LA and PCT to work closely together to ensure that all required documentation is identified. PCT to contract the providers where necessary to obtain necessary paperwork for LA or other future commissioner
LES contracts – lack of appropriate contracting mechanism for LA to use .	Confirmation given by DH that LESs that terminate after 31/3/2013 or that are being extended into 2013/14 can stay on their existing SLA as long as the receiver agrees **Guidance :** http://www.commissioningboard.nhs.uk/files/2012/03/fact-enhanced-serv.pdf
Non-standard contracts may have been used - lack of ownership of data and information	Identify non-standard contracts, assess the risk, be open with receivers, ensure next contract addresses these issues

Stage 3 –Transfer scheme and shift

The purpose of the shift phase is to ensure:

- Safe effective legal transfer of clinical contracts from the sending organisation (e.g. PCT) to the new commissioning organisations (e.g. LA or other hosted bodies e.g. PHE)
- Ensuring continuity of services and minimising risk to our patients
- Certainty and continuity for providers and receiving commissioners
- Completion of the transfer schemes (legal document for contract transfer)
- Transfer of contract documentation between 'senders' and 'receivers'
- Handover packs created through discussion with receivers

Shift Guidance: http://www.dh.gov.uk/health/2012/11/shift-phase-planning/

Stage 3 Shift - Next steps and timeline

	November 12	December 12	January 13	February 13	March 13	April 13
To be completed by (PCT) Sender finance/ contract leads	15th November 1st upload of transfer scheme	13th December 2nd upload	17th January FINAL upload Subject to change requests and other exceptions	25/26/27th Feb Secretary of State sign-off of Transfer Scheme		
				28th Feb –>March Sender & Receiver Board meetings for sign-off of Transfer Scheme		
	Complete Annex 2 - list of Assets and liability (excluding clinical contracts) and separate template for clinical contracts. List of contracts will be split into 3 sections: Contracts for transfer / Contracts for re-negotiating/ Contracts for terminating. Annex 3 – Complete all sections and enter refer to Annex 2 , Annex-A etc for detailed listings.					
Process to be led by Local Government		Liaise with Committee / Democratic Services at least one month in advance to ensure that the report is on the Forward Plan.	Committee / Cabinet meeting to notify process for contract Transfer Scheme & to agree to delegate authority to sign-off Transfer Scheme			
				28th Feb –>March Sender & Receiver Board meetings for sign-off of Transfer Scheme		

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Appendix 3

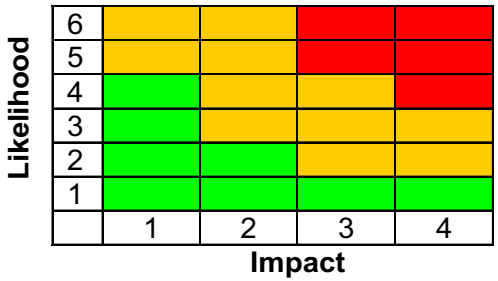
Risk assessment to delivery of PH functions in LB of Merton from April 2013 – DraftV2

ID/ Ref	Risk Title	Risk Owner	Cause & Effect	Risk Score I x L = total risk	Existing Controls	Mitigating actions	Comments (incl. action required)
Transition Risks							
1.	Failure to achieve 'fit for purpose' staff capacity in PH	Director of Public Health – NHS SM	Delays in recruitment to leadership positions, and finalisation of staff transfer/ recruitment.	3 x 4 = 12 (Amber)		NHS/PCT HR to be kept aware of potential vacancies and importance of early recruitment; engage LA HR if required.	Monthly review. Next review by end of Feb'13.
2.	Failure to satisfy robust 'Information Governance' requirements	Public Health Intelligence Specialist	Lack of assurance in IT architecture (e.g. N3 connectivity); and authority for role-enabled access to health care activity data.	3 x 5 = 15 (Red)	DH aware of issues as addressed in 'Gateway reference: 18033' published in September 2012.	Contingency plan to use N3 tokens agreed if N3 connection not fully in place by 1 April 2013.	Monthly review. Next review by end of Feb'13.
3.	Failure to outsource provision of integrated smoking cessation and health promotion service	Director of Public Health – NHS SM	Delay in completion of HR consultation process with current staff in smoking cessation, and selection of preferred provider.	3 x 2 = 6 (Amber)	HR Consultation response completed; selection of preferred bidder process underway and due for completion by middle of Feb'13 (earliest).	The Transfer Scheme will be amended to retain the service and staff while it is retendered.	Update by end of Feb '13.
Performance Risks							
ID/ Ref	**Risk Title**	**Risk Owner**	**Cause & Effect**	**Risk Score I x L = total risk**	**Existing Controls**	**Mitigating actions**	**Comments (incl. action required)**
4.	Failure to reach smoking cessation and health promotion targets	PH (Senior) Commissioning Manager	Smoking cessation service accessed by fewer people due to low smoking prevalence, resulting in fewer people setting '4-week quit date' targets.	2 x 5 = 10 (Amber)	Performance management via DPH to 'Senior Management Team'.	Outsourced and integrated smoking cessation and health promotion service; targeting 'core' and 'hard-to-reach' groups; building on national campaigns.	

Dr B Rodrigues, 23 January 2013

ID/ Ref	Risk Title	Risk Owner	Cause & Effect	Risk Score I x L = total risk	Existing Controls	Mitigating actions	Comments (incl. action required)
5.	Failure to achieve national Chlamydia screening targets	PH Sexual Health Commissioning Manager/ Officer	Less than adequate funding to achieve 2,400 chlamydia diagnoses per 100,000 15-24 year olds per annum.	2 x 5 = 10 (Amber)	Performance management via DPH to 'Senior Management Team'.		
6.	Failure to reach 'NHS Health Check' targets	PH (Senior) Commissioning Manager	Delayed implementation of programme.	2 x 3 = 6 (Amber)	Performance management via DPH to 'Senior Management Team'.		

Risk tolerance matrix



Likelihood
6 – Very high
5 – High
4 – Significant
3 – Possible
2 – Low
1 – Almost impossible

Impact
4 – Catastrophic
3 – Critical
2 – Significant
1 – Marginal